Green County Public Health COVID Vaccine Clinic

# Vaccine Administration Record and Screening

Green County Public Health
Prevent. Promote. Protect.

Information collected on this form will be used to document authorization for receipt of vaccines. The information will be shared through the Wisconsin Immunization Registry (WIR) with other health care providers directly involved with the patient to assure completion of the vaccine schedule. Information collected on this form is voluntary and confidential. **Please Print.**

**Client Name: Last:** | | | | | | | | | | | | | | | **First:** | | | | | | | | | | | | **MI:** |

**Age:** _____ **Date of Birth:** month:_____ day:_____ year:_____ **Gender:** ☐ Male ☐ Female ☐ Other

**Address:**_____ **City:**_____ **Zip:**_____**Telephone:**_____

**Email Address:** _____ **Medicare/Medicaid Number:** _____

**Ethnicity:** ☐ Hispanic ☐ Non-Hispanic **Race:** ☐ Black/African American ☐ American Indian ☐ Asian ☐ White ☐ Other race

| Questions for person receiving vaccine | Yes | No |
|---|---|---|
| 1. Are you sick today? (fever, cough, shortness of breath, nausea/vomiting in the last 24 hours) | ☐ | ☐ |
| 2. Are you currently in isolation after testing positive for COVID-19, or have you been exposed to someone with COVID-19 in the past 10 days? | ☐ | ☐ |
| 3a. Have you ever had an anaphylactic reaction?<br>3b. Have you ever had an anaphylactic reaction to a component of the COVID-19 vaccine, another vaccine, or an injectable (e.g., intramuscular, intravenous, or subcutaneous) therapy? List: | ☐<br>☐ | ☐<br>☐ |
| 4. Are you moderately or severely immunocompromised? | ☐ | ☐ |

I have been given a copy and have read, or have had explained to me, information about the diseases and the vaccine to be received. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of receiving a vaccine approved by the FDA or under an Emergency Use Authorization from the FDA. I consent to receive the vaccine in a public location. I have been made aware of the appropriate time I am expected to be monitored for post-vaccination reactions based on my risk factors. **I understand the benefits and risks of the vaccine requested and ask that the vaccine be given to me, or in the case that I am a guardian, my chil**d.

**Consent Signature:** _____ **Date:** _____

**Are you receiving** ☐ **Dose 1** ☐ **Dose 2** ☐ **Dose 3** ☐ **Booster**

| For Vaccinator | | | | |
|---|---|---|---|---|
| Vaccine | Dosage | Site | Trade name/Manufacturer Lot Number | Expiration Date |
| COVID-19 | .5 .3<br>.25 .2 | RD<br>LD | | |

Signature and Title – Person Administering Vaccine:_____ Date:_____